

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-017039

STATE FILE NUMBER

Registration District No. 274

Primary Registration District No. 2052

Registrar's No. 153

DO NOT WRITE
ON THIS STUB

AMENDED

FILED MAY 6 1963

| | | | |
|---|-------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Pettis</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Benton</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Sedalia, Mo.</u> | | c. CITY OR TOWN <u>Warsaw</u> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Bothwell Hospital</u> | | d. STREET ADDRESS (If outside, give location) <u>Warsaw, Mo.</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Dorothy</u> Middle <u>Goodloe</u> Last <u>Drake</u> | | 4. DATE OF DEATH Month <u>April</u> Day <u>26</u> Year <u>1963</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>white</u> | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>Jan. 7, 1887</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u> | |
| 11a. FATHER'S NAME <u>Charles Harrison Drake</u> | | 11b. MOTHER'S MAIDEN NAME <u>Charlotte Tompkins</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u> | | 16. SOCIAL SECURITY NO. <u>No.</u> | |
| 17. INFORMANT <u>Pauline Autrieth</u> | | 17. ADDRESS <u>Warsaw, Mo.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary infarction</u> Conditions, if any, which gave rise to above cause (b), stating the underlying cause last. <u>Pulmonary thrombosis</u> DUE TO (b) <u>Pulmonary thrombosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____ PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u> | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | | 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____ | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ | |
| 20f. CITY, TOWN, OR LOCATION _____ | | COUNTY _____ STATE _____ | |
| 21. I attended the deceased from <u>1947</u> to <u>1963</u> and last saw her alive on <u>4-26-63</u> | | Death occurred at <u>6:40 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | |
| 22a. SIGNATURE <u>E. G. Rodman, M.D.</u> (Degree or title) | | 22b. ADDRESS <u>Warsaw, Missouri</u> | |
| 22c. DATE SIGNED <u>4-27-63</u> | | 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | |
| 23b. DATE <u>Apr. 28, 1963</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Riverside Cemetery</u> | |
| 23d. LOCATION (City, town, or county) <u>Warsaw, Benton Co., Mo.</u> | | (State) _____ | |
| 24. FUNERAL DIRECTOR <u>John F. Reser, Warsaw, Mo.</u> | | 25. DATE RECD. BY LOCAL REG. <u>April 28, 1963</u> | |
| 26. REGISTRAR'S SIGNATURE <u>Frances Shelby</u> | | 26. REGISTRAR'S SIGNATURE <u>H. Anderson</u> | |

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MAY 7 1963

0200
0200

1004

0-1

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

John F. Reser

Licensed Embalmer No.

4098

P. O. Address

Warsaw

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.